Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
University of Texas Health Science

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-13-3244-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 5, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The main issue in this case is the fact that … Workers' Compensation insurance had already approved and authorized the agreed upon fee prior to Medicare's fee release of code L6715. Upon payment for the prosthesis and services, they did not recognize the authorization and fee and instead based the payment for code L6715 on the new Medicare HCPCS fee that was established after their authorization."

Amount in Dispute: $78,351.45

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DMEPOS fee schedule for July 2012 indicates the reimbursement is $2,945.67 per unit for Texas. The requestor billed four units; therefore, Texas Mutual took the DMEPOS amount, multiplied it by 125% (consistent with Rule 134.203(d)(1), to get DWC unit reimbursement of $3,682.09. This amount was then multiplied by four to obtain the MAR of $14,728.35, the amount Texas Mutual paid the requestor."

Response Submitted by: Texas Mutual Insurance Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2012	DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics)	$78,351.45	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 8 Texas Insurance Code §1305.006 establishes insurance carrier liability for certain out-of-network care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- CAC – 193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- 724 - NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES

Issues

1. Is the insurance carrier liable for disputed out-of-network health care services?
2. Did the requestor support that additional reimbursement is due?
3. Is the requestor entitled to reimbursement?

Findings

1. 8 Texas Insurance Code §1305.006(3) states that an insurance carrier that establishes or contracts with a network is liable for "health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103." Review of the submitted information finds that the requestor is an out-of-network provider that provided disputed health care pursuant to a referral from the injured employee's treating doctor that had been approved by the network pursuant to Section 1305.103. This approval was confirmed by Mr. Richard Ball employee of Texas Mutual Insurance. Accordingly, the Division concludes that the insurance carrier is liable for the services in dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. 28 Texas Labor Code §134.203(b) states, "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Review of submitted the medical claim finds the date of service to be 9/19/12. Pursuant to the above the Medicare Pricing, Data Analysis and Coding, (https://www.dmedac.com/dmecsapp/do/feesearch), finds the fee to be $2,945.67 for the date of service in dispute. Therefore, the requestor's position that this claim is not subject to the Medicare fee schedule is not supported. The services in dispute will be reviewed per applicable rules and fee guidelines.
3. 28 Texas Administrative Code §134.203(c) is the applicable division fee schedule for calculation of the maximum allowable reimbursement for the services in dispute. For services in 2013, the maximum allowable reimbursement = 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthethics, Orthotics and Supplies (DMEPOS) fee schedule; (2,945.67 x 125% = $3,682.09 x 4 units = $14,728.36.

   The total allowable for the disputed services is $14,728.36. The carrier paid $14,728.36. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 17, 2014 Date

Signature	Medical Fee Dispute Resolution Manager	July 17, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.